WELCOME TO OUR PRACTICE

Reddy Medical Group/Reddy Urgent Care

NEW PATIENT INTAKE FORM

Patient's Personal Information:
Last Name: ____________________First Name: ___________________ MI: _______
Previous Name: ___________________

Mailing Address: ____
Apartment number ______ City _____________ State __________ Zip Code _________

Physical Address: ____
Apartment number ______ City _____________ State __________ Zip Code _________

Home Phone____-____-_____Cell Phone____-____-_____Work Phone____-____-____
Date of Birth ___/___/____ Social Security Number ______-_____-______ Sex: M F

Email Address: _____________________________________
Pharmacy of Choice (Specify Location): ____________________________________
Primary Care Physician (Full Name) ____

Marital Status: Single Married Divorced Widowed

Student Status: Full time, Part time, N/A **Employment Status**: Full time, Part time, N/A
Ethnicity:___________________**Language**:__________________ **Race**:__________

Emergency Contact:
Name: _________________________________ Relationship: ____________________
Address: ____
Contact Number: ______________________

Responsible Party (Complete this section only if someone other than the patient is financially responsible or the patient is under the age of 18)
Name: Last: ____________ First: _____________ MI: ___ Date of Birth ___/___/_____
Address: ____
City: ________________ State: ________ Zip: _______ Relationship: _________________
SSN _____-_____-______ Home Phone ____-____-_____ Work Phone ____-____-____

Employer Name: ____
Employer Address: ____

Were you injured on the job? YES or NO. If yes, date of injury: ________________
Did you report the accident to your employer? YES or NO

For Verification of all Insurance Benefits, We require a copy of your Insurance Card and Photo ID at the time of Registration

Primary Insurance Name: ____
Address: ____
Phone Number: __________________________
Member ID Number: ______________________ Group Number: ____________________
Policy Holder's Name: ________________________ D/O/B: ____________________
Policy Holder's Address:_______________________ Phone Number:__________________

Secondary Insurance Name: ____
Address: ____
Phone Number: ___________________________
Member ID Number: _______________________ Group Number: __________________
Policy Holder's Name: ________________________ D/O/B: ___________________
Policy Holder's Address:_______________________ Phone Number:_________________

Authorization and Assignment:

I authorize Reddy & Associates, LLC to release medical records to employer or any insurance company with whom I have medical benefits for the purpose of filing medical claim. I also authorize any physician, hospital or clinic to provide medical information required in the course of my examination or treatment. ***I give consent for Reddy & Associates, LLC physicians to obtain Rx history from external sources.***

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative.

Insurance is filed as a courtesy. It is patient/guardian responsibility to ensure all bills are paid. All co-pays, deductibles and co-insurance are due at the time of services.

Assignment of Benefits Payment:

I authorize my health insurance benefit plan to pay directly to Reddy & Associates, LLC. I understand that I am financially responsible to Reddy & Associates, LLC for any non-covered charges. If I am a self pay patient, I understand that I am responsible for all charges in full at the time of service. ***I have read and understood the Financial Policy terms and conditions revised on 11-15-2013***

______________________________ ___________________________ ____________________
Signature *Relation to patient* *Date*

HOW DID YOU HEAR ABOUT REDDY MEDICAL GROUP/REDDY URGENT CARE?

Web Newspaper Magazine Radio Billboard Person Other:_____________

Revised: 11-15-2013